

**PERSONAL CARE/DIRECT CARE SERVICES CHECKLIST**

**FACILITY:** \_\_\_\_\_

**Resident:** \_\_\_\_\_ **Date/Time** \_\_\_\_\_

<b>Personal care/Direct Care services</b>	<b>Needed Y/N/NA</b>	<b>Provided Y/N/NA</b>	<b>Time</b>	<b>Comments</b>
Assisting the Resident to Eat (include meals and offering food and fluids between meals)				
Mouth, Teeth, Denture Care				
Bathing (include partial baths if individual suffers from incontinence)				
Skin Care				
Hair Care				
Shaving				
Nail Care				
Elimination (Toileting and Incontinence Care)				
Assisting the Resident to Dress				
Care of Eyeglasses and Hearing Aids				

<b>Personal care/Direct Care services</b>	<b>Needed Y/N/NA</b>	<b>Provided Y/N/NA</b>	<b>Time</b>	<b>Comments</b>
Bedmaking				
Special Needs/Services				
Behavioral Management (includes a degree of redirection required to keep individual focused on tasks at hand)				
Medication Management				
Activities (include structured and non-structured appropriate to the individual's functional level)				
<b>TOTAL TIME</b>				